Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address:	MFDR Tracking #: M4-10-3900-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #: EMPLOYERS MUTUAL CASUALTY CO Box #: 19	Date of Injury:
	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: A position summary was not submitted.

Principle Documentation:

1. DWC 60 package
2. Receipts
3. Total Amount Sought $3363.87

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "The claimant's response is not timely. The dispensing pharmacy did not seek preauthorization for the dates in dispute. The pharmacy did not present the carrier with a DWC-66 form. The dispensing of medications was not in compliance with the relevant provisions of the ODG. Please see attached PLNs, EOBs, and peer review reports."

Principle Documentation:

1. DWC 60 package

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
05/20/2009 – 08/18/2009	216	Out-of-Pocket Expenses for prescriptions	$3363.87	$0.00
Total Due:				$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

1. Medical Fee Dispute Resolution received the request for medical dispute resolution on April 26, 2010. Dates of service 01/09//2008 through 04/23/2009 were not filed within the one-year filing time as required by 28 Texas Admin Code Section §133.307(c)(1); therefore, these dates of service will not be reviewed.

2. This dispute relates to out-of-pocket expenses with reimbursement subject to the provisions of 28 Texas Admin Code Sections §133.270 and §134.504.

3. The Insurance Carrier's response indicates that the disputed dates of service were denied reimbursement based on "216

– Denied based on findings of review organization (Peer Review)."

4. According to 28 Texas Admin Code Section §133.305, Medical Fee Dispute Resolution does not have the authority to review disputes with issues of medical necessity.

5. Pursuant the 28 Texas Admin Code Section §133.307(e)(3)(G) the Division concludes that this dispute was submitted to the incorrect venue. As a result, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d), §413.031 and §413.0311
Texas Administrative Code Sec. §133.270, §133.305, §133.307, §133.308 and §134.504

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. §413.031, the Division has determined that the Requestor is entitled to $0.00 reimbursement.

Authorized Signature	Auditor III Medical Fee Dispute Resolution	June 25, 2010 Date

PART VIII: : YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.